Ministry at the End of Life

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The view from 88: The passing of friends and the passage of time

By Becky Evans

Now that I have reached the ripe age of 88, I am well aware that I am now on the last leg of my journey. Four years ago, I finally sold my house and moved into an independent living complex, Lexington Village, in suburban Milwaukee. I am settled and content in my new home and no longer have a five-year plan for the future. What matters most, what I appreciate most, is Now.

I have kept connected to the NACC since I was first hired in 1985, but it will soon be time for me to retire for the third time, this time as proofreader for the NACC Now biweekly email. I will do so as reluctantly as I did the first time — as Vision editor in 1999 — and again in 2010 as the part-time assistant for certification renewal. NACC has seemed like home to me.

Although I do not have a life-threatening illness, I often think about my death and wonder how soon I will die. I have inherited genes for long life from both sides of my family, so I could live well into my 90s. Before I reached 70, I seldom contemplated my own death. The future seemed indefinite; life would go on forever, it seemed.

But 18 years ago, when I suffered a brief, but life-threatening stroke, I realized that death might be just around the corner. I learned then that when death might not be far off, life seems more fleeting, and the days become ever more precious as they pass, more quickly than before. After my stroke, looking out the window from my hospital room, the sky seemed a more beautiful blue, the grass and the leaves on trees seemed greener, and the bustle of human traffic on the street and people rushing in the hall was something sweet to savor.

Now, I consider myself blessed each morning that I wake and can put my feet on the floor. I anticipate that I might feel pain or sadness, but I rise with hope and gratitude for the new day. It comes as a gift, despite the distractions of the physical aches and pains that inevitably accompany age, when the body lets us down. There are days I grumble when painful knees get the better of me, days I might feel low, but there are other days when I could be bursting with such great happiness and joy that I might be able to say, like Miss Sook in Truman Capote’s beautiful “A Christmas Memory,” “I could leave the world with today in my eyes.” As a woman choosing the path of optimism, the glass more than half full, I have adopted as my watchword a very old one: “All shall be well ... and all manner of thing shall be well.”

By now, all my closest longtime friends are gone. Several other elderly dear friends have also recently died. Many residents in my building are widows in their 80s and 90s, so death or departure due to failing health is frequent. I hope and pray that my apartment here will be my last home. I echo the comment of my new friend Joan on the third floor, “I want to be carried out feet first.”

Losing dear friends has meant dealing frequently with grief. My late good friend Harry Davis often said that the hardest part of growing old is surviving our friends. We may bend under the weight of their absence, but I have learned that to grow very old gracefully means choosing to live at peace with increasing losses, not letting them turn into despair or constant lament. The
late beloved friends I still keenly miss remain with me in memory. I keep their photographs and their writing close by to help me, when I may feel bereft or lonely, to rekindle the good times, the closeness, the laughter and tears we shared.

In addition to physical health problems, increasing deafness, and mild but sometimes distressing memory loss, I have become more fearful at times — fearful of falling, fearful when driving. I do not fear death, but I fear the possibility of not being able to die well — though my years with the NACC have taught me to prepare for dying. I trust I will be able to accept whatever comes and pray I may cope bravely with any illness that would make me lose my independence and become a burden. To lessen this worry, I have all my legal paperwork up to date, including naming my daughter as my durable power of attorney for both healthcare and finances. Though I have not chosen a gravesite, we have made arrangements for cremation of my body.

I try to remain as physically active and mentally stimulated and creative as I can. Bingo and card games are a big source of entertainment in my building, but they are not for me. “Well, it passes the time,” my 93-year-old neighbor Alice commented, when I told her I did not find them fun or challenging. I prefer to spend my time in writing and reading. I like to sit in the stillness for long stretches, feel at peace with myself and the world – perhaps hold an ailing friend in the light, as Quakers do in prayer. (I am a member of the Milwaukee Meeting of the Religious Society of Friends.)

Loss of mobility due to increasing arthritis, with dependence on a four-wheel walker, has kept me closer to home these days. For the past three years I have invited a group of talented poet friends to gather monthly around my dining table to read aloud and discuss poems they have written or ones they especially enjoyed reading. This has been a soul-satisfying activity for me, when the poets arrive rejoicing at the opportunity to be together.

The poet, nonfiction writer, and writing instructor Pat Schneider says in her latest book, How the Light Gets In: Writing as a Spiritual Practice, that in writing, as in prayer or meditation, we sit down and open ourselves to mystery. I think of my own writing, especially of poetry, as a spiritual practice, and as therapy. Much of my writing, in poetry and prose, is narrative. So much healing occurs when we tell our stories, to ourselves, to others.

Writing is an excellent way for me to document the past and record memories – of milestones, from growing up to aging, the good and the tough times, failures and mistakes as well as accomplishments, of knowing who I have become. I will probably wrestle with the big existential questions until the end. In the meantime, I pray I may spend whatever days are left to me looking at life and this beautiful, broken world with continual amazement, wonder and awe, and offer praise and gratitude for the journey.

I had to downsize my personal library by many hundreds of volumes before moving. But along with classics and many books of poetry, some helpful books on death and dying, on meditation and spirituality, came with me in addition to my Bibles: for example, Cardinal Bernardin’s reflections as he faced imminent death as a friend in Gift of Peace and Stephen Levine’s A Year to Live: How to live this year as if it were your last.
One of the common poignant experiences I have shared in old age is the wonder, the mystery of “is this the last time?” as the seasons and the annual celebrations with the people dearest to us pass. Retired hospice chaplain Deborah Gordon Cooper has captured this same experience extremely well in the final poem of her latest beautiful book of poems, *Blue Window*, composed when she was given the gift of an artists’ retreat in County Kerry, Ireland.

The poem title, “Because,” is the same as the first line:

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Because
October’s ending
and November looms

each time
I hear a loon
call in the bay

I think that this
may be the last time.

The last magenta
maple leaves

unlatch
the small machinery

that holds them
to the branch.

I pray we all
might fall
as softly.
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Amen. May we all fall as softly.

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*Becky Evans was the editor of Vision from 1985 to 1999 and has served the NACC in other capacities since then.*
Education about advance directives can pay dividends later

By Diane McCarthy

With tears in her eyes, the wheelchair-bound resident thanked me for the presentation on palliative care and advance care planning that I had just given in her nursing facility. She had struggled with the recent death of her sister from brain cancer after she decided to forgo treatment. The resident had thought that her sister’s choice went against Catholic teaching and bordered on suicide. She was relieved to hear about Directive 57 of the Ethical and Religious Directives for Catholic Health Care Services: “A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient’s judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community.”

As the parish education coordinator for the Archdiocese of Boston Initiative for Palliative Care and Advance Care Planning, I travel throughout the archdiocese and beyond, speaking about palliative care, advance care planning, and how Church teaching supports both. After the archdiocese led efforts to resist a 2012 Massachusetts ballot referendum to legalize physician-assisted suicide, Cardinal Seán O’Malley realized that most Catholics had not heard of palliative care, or if they had heard the term, had misconceptions about it. The cardinal desired to educate his faith community about palliative care as a way of ministering to a vulnerable population in our midst: those with serious illness, their caregivers and loved ones. Palliative care is also an excellent refutation of the need for physician-assisted suicide.

MC Sullivan, our program director, is a nurse, attorney, and bioethicist with a passion for the more widespread provision of palliative care. She designed and implemented the program to focus on education and outreach, ethics, and advocacy. MC works with ethicists from around the globe, making Church teaching on issues in palliative care more accessible. In her advocacy work, she promotes public policy that supports palliative care with media, state, and national legislatures and others. Our initiative also serves as a model and resource to other Catholic dioceses and organizations seeking to develop palliative care education programs.

Before my current position, I served as a chaplain in Catholic long-term care for five years. Those experiences prepared me well for doing this education work. I spent much time in resident and family meetings, at ethics committee meetings and at the bedside of people journeying with serious illness and at the end of life. Frequently I would hear, “Well, we are Catholic. We have to do everything.” That is not what the Church teaches. I often share with my audiences a statement that Pope Francis made in November 2017 that illustrates this well: “And even if we know that we cannot always guarantee healing or a cure, we can and must always care for the living, without ourselves shortening their life, but also without futilely resisting their death. This approach is reflected in palliative care, which is proving most important in our culture, as it opposes what makes death most terrifying and unwelcome – pain and loneliness.”
Once I was going into a family meeting with the son of a woman who was being recommended for hospice services. The man said, “I know exactly what is going to happen. The day she goes on hospice, you will give her a big shot of morphine and she will die.” There is so much misinformation in our community about what palliative care is, what hospice care is, and what the Church teaches.

Typically, my presentation begins with a case study from the Center to Advance Palliative Care website. Then I define and describe palliative care: who might be a candidate for it, when and how it is started, and topics that could be discussed with your palliative care team. Next I discuss advance care planning and tools to help people start to think about their values, what is important to them, how they want to be cared for if they can’t speak for themselves in the future, and how to have conversations with their loved ones — remembering that in our death-denying society, it can be difficult to start these conversations. Finally, I review the Church teaching on palliative care and advance care planning. I also provide handouts for further research and study.

I have seen the great benefits of this kind of education. People leave the presentation empowered to make decisions for themselves or a loved one that align with their Catholic faith. My 81-year-old mother had told me that she had never heard of the term *palliative care* until I started working for the archdiocese. But after my presentation she said, “I feel so much more peaceful now in thinking about my future.” And isn’t that what we want for our faith community? Peace in accepting the end of our earthly life as we journey to our true home with God.

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The beginnings of palliative care: Teamwork, respect, self-awareness

By Linda Piotrowski

The roots of my chaplaincy ministry lie deep within long term care. My first job as a professional chaplain was ministering to retired Sisters of St Francis Assisi at Marian Franciscan Home in Milwaukee. They were the first religious in the United States to place their infirm sisters in a nursing home. I was honored to be a part of that new venture.

I learned from the sisters and other residents in the nursing home how to face diminishment and death with courage and grace. Being a witness to their tenacity, love of life, declining health, and eventual deaths taught me that while death is often painful, it is not to be feared. I learned that human beings can gracefully embrace their final days with hope and courage, all the while teaching those of us around them how to support them.

That experience, along with others who mentored me, helped inspire me to specialize in palliative care. Nursing home ministry is an excellent example of palliative care long before we called it that or had specializations such as the new palliative care certification. But the foundation is the same as that for any chaplain. A good building block is the transcendental imperatives taught by theologian Bernard Lonergan: to be attentive, intelligent, reasonable, responsible, and committed to love. If we forget these principles, we do so at our own peril and that of the people we seek to serve.

Not everyone we meet embraces a religion. However, at the core we all are spiritual beings. As Ira Byock, MD, my former boss and mentor, writes, “Human spirituality arises in response to the awe-inspiring and terrifying mystery of life and the universe. We reflexively seek to make meaning of our experience in the world and make or strengthen our connections to others.”

Ira Byock sought to develop a team both interdependent and interdisciplinary. Team members held deep respect for each person’s discipline. We learned to share our vulnerabilities as well as our strengths. We learned from one another. We called each other out when necessary.

We cultivated deep respect for the individual. Yvonne Corbeil, a team member, often reminded us that words have great power, and while team meetings were a time to share successes, failures, and frustrations, we needed to speak about a patient or family member as if that person were present in the meeting with us. Respect for the uniqueness of each individual is the cornerstone of good ministry and palliative care. This extends to teammates and all staff.

For every team member, but especially for the chaplain, our journey with each person begins self-awareness. We don’t bring God into any situation. God is already there. God is already and always present with each person before we show up.
In the face of suffering and death, we must ask ourselves what our own faith teaches about life and death, suffering and pain, and how this might affect how we interact with the patient and family. What is your personal history with suffering and death? Where do you draw strength in the midst of great challenges? With what space of privacy and trust do you surround yourself? Whom do you allow into your circle of beliefs, feelings, hopes, and fears? What rituals, beliefs, and practices help you to cope? Being aware of this enables you to decide how to invite the other to share their feelings and beliefs about their own illness, suffering, and impending death.

Before everything else, palliative care is ministry to and with patients and families. Having an open and compassionate heart is what allows another to have the sense that you are someone they can trust with their story. Helping others to maintain hope in the face of defeat and disappointment is a sacred trust. Not giving false hope, but reframing hope for the right thing rather than for the impossible, is most important.

Ministry to the dying is not for the faint of heart. Rejection is a part of this ministry. When I was held at arm’s length or outright refused, I learned that each story is to be respected and honored whether or not I am invited in.

When patients’ lives are out of their control and they are powerless to hold people at bay, at times the chaplain is the only staff member they can refuse. This ministry is not about the chaplain — it is about the person undergoing this life-changing experience.

Ira Byock, more than any other mentor of mine, impressed upon me the need for a chaplain to think and behave as a true professional. Respect, he taught me, is gained by doing research, making presentations at conferences and workshops, as well as publishing articles and chapters in professional publications. He taught me and other team members to respect and partner with other disciplines, to publish and speak not only in our own membership groups but for other professional organizations.

As I look back over my years of ministry with those who are standing at the threshold of life and death, I feel a deep sense of gratitude and wonder that I was invited into such an intimate and personal time.

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New, improved palliative care guidelines enhance view of spirituality

By David Lichter  
Executive Director

This issue of Vision is dedicated to end-of-life care. We are grateful to all of the authors who have contributed. Certainly, the clinical discipline of palliative care has contributed greatly to integrating spiritual care and viewing it differently from just a set of protocols and practices. I appreciated Timothy Daalman and his co-authors,¹ who described spiritual care at the end of life as “a series of highly fluid interpersonal processes in the context of mutually recognized human values and experiences, rather than a set of prescribed and proscribed roles.” While spiritual care at end of life is indeed a “series of highly fluid processes,” the board-certified chaplain is comfortable in this realm and helps guide the patient, family, and interdisciplinary team through identifying, exploring, and addressing the meaning, purpose, and myriad of relationships that facing end-of-life decisions require.

If you have not yet reviewed the Clinical Practice Guidelines for Quality Palliative Care, fourth edition, please do. It improves significantly upon the third edition (2013), especially Domain 5, dedicated to helping patients and family face the spiritual, religious, and existential issues they encounter. I want here to highlight three improvements I appreciated.

First, it uses the more expansive definition of spirituality while building on the excellent definition of spirituality provided us in 2009 by the National Consensus Project. As you recall the 2009 definition was: “Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred.” The fourth edition’s description of spirituality is “a dynamic and intrinsic aspect of humanity through which individuals seek meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices.” Thus, the Guideline 5.1 makes special note of assessing and respecting the spiritual beliefs and practices of the patient and his/her family, as well as highlighting the importance of the entire interdisciplinary team to be aware of their own unique spiritualities and “opportunities are provided to engage the staff in self-care and self-reflection regarding their own spirituality.” The chaplain both models and assists the IDT in the self-reflection and self-care.

Secondly, in NCP 5.2, the fourth edition revises the list of potential areas to examine in a spiritual assessment. Again, I think this is an improvement. The third edition included “spiritual and existential concerns” such as: “life review, assessment of hopes, value, and fears, meaning, purpose, beliefs about afterlife, spiritual or religious practices, cultural norms, beliefs that influence understanding of illness, coping, guilt, forgiveness, and life completion tasks.” This fourth edition includes a more organized set of “spiritual concerns” such as but not limited to: “a. Sources of spiritual strength and support b. Existential concerns such as lack of meaning, questions about one’s own existence, and questions of meaning and suffering c. Concerns
about relationship to God, the Holy, or deity, such as anger or abandonment d. Struggles related to loss of faith, community of faith, or spiritual practices e. Cultural norms and preferences that impact belief systems and spiritual practices f. Hopes, values and fears, meaning, and purpose g. Concerns about quality of life h. Concerns or fear of death and dying and beliefs about afterlife i. Spiritual practices j. Concerns about relationships k. Life completion tasks, grief, and bereavement.” I believe it is helpful to begin with identifying the sources of spiritual strength and support critical to addressing the others. In fact, NCP 5.3 emphasizes “maximizing patient and family spiritual strengths.”

Thirdly, the new edition added a fourth guideline regarding the need for ongoing care, remaining vigilant to changing circumstances and flexible with an evolving care plan. NCP 5.4.1 describes this practice as: “Throughout the trajectory of the patient’s illness, the IDT performs spiritual screening to identify new or emergent issues, identifying services and supports to help navigate these transitions. Changes in prognosis and other significant transitions prompt reassessment of spirituality.” This practice aligns well with Daalman and colleagues’ description of spiritual care as “a series of highly fluid interpersonal processes in the context of mutually recognized human values and experiences, rather than a set of prescribed and proscribed roles.”

These are just three improvements I note. However, the entire document invites a thorough read. I am particularly grateful for the integration and prominence of the board-certified chaplain in Domain 5. I hope you will read this at your convenience.

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¹ https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2532767/
Hear My Voice: Patients get a chance to put their legacy on paper

By Beba Tata

“When I first received the news that I had cancer, I froze. Then I sat on the floor of my doctor’s office. My husband came down and held my shoulders, we sat in that position for a long time before I was able to come out of the trance.”

When many people first hear the news of a possibly fatal diagnosis, the immediate moment seems to come to a standstill. It is shocking and mind-blowing. One 40-year-old woman who had had cancer seven times told me, “Each time I am told that I have cancer, it always sounded like a time bomb.” After the initial shock, most people start thinking about the process of their death, the disease burden and how life will look like from then on. They think about the impact their illness will have on their families, friends, and community. They wonder who will be there for them and care for them as their illness progresses.

The Hear My Voice project at the Mayo Clinic in Rochester, MN, lets people with neurologic diseases and other advanced illnesses tell their stories while they can. The project seeks to capture the uniqueness of each person’s story and to understand its significance and how it gives meaning to them. A spiritual legacy document is then prepared that holds their beliefs, values, and life-learned wisdom.

To produce the document, a board-certified chaplain records an interview, either in person or by phone, working from a script of questions. The interview provides the participant with an opportunity to review spiritual beliefs, values, experiences, and sources of spiritual comfort and hope, as well as spiritual struggle, spiritual distress, and spiritual meaning. The interview is preceded by a validated questionnaire measuring spiritual well-being and quality of life, and followed by two follow-up questionnaires. Interviews last 45 to 60 minutes over one or two sessions.

The process of the HMV interview and the empathetic presence of the chaplain create a sacred space and invite people to review their lives in the light of their spirituality and tap into resources that may have otherwise been suppressed. Through this study I have experienced the power of voice. Telling their stories was part of the legacy that the people wanted their loved ones to hold on to and remember them by.

In the three years that I have participated in the HMV project, I have seen illness become a transformative event. I have seen people move from shock to acceptance, from desolation to consolation. I have heard expressions of perseverance, positivity and hope that have helped people adjust to diagnosis and give comfort during treatment. The preliminary results of the study have indicated increased religious coping, peacefulness, emotional wellbeing and quality of life. Many patients expressed a renewed relationship with God that has given them peace, hope, acceptance and the ability to journey with their cancer. One woman said, “I have made peace with my God. I have peace with my children and with my family. I am ready to go anytime he wants to take me home.”
Many saw their fears dwindled and their hopes rekindled as they experienced the love of their spouses and their children. A 55-year-old woman said, “I am so glad there has been a strong sense of connection for me and my girls and my husband through this whole cancer thing.”

Many expressed a great sense of resilience that they did not have when they were first diagnosed. “I would say that I’m proud I have reached this point, and I did not really drop down during the process of illness,” said a 34-year-old woman. “I am proud that even though I do have always a member of the family around, that I’m still standing strong and I can handle it, I would say.”

People not only used resources they had at hand; they reached out to the rich resources that were cultivated in the course of their lives. I interviewed a legally blind 91-year-old who used to sing. She radiated joy when she talked about music. She could not see, but music still lifted her spirits. A younger woman, 48, emphasized that if she should lose her ability to read, “I want people to know it is really important to me that I be read to... that is going to be a big source of happiness for me to be able to be read to, just like I did with my kids.” A 96-year old told me, “I cannot forget my devotion to Mary. I reach out to God and that sustains me every day.”

It is always an amazing moment for me when I bring the legacy documents to the patients. The smiles on their faces can only be described as priceless. They are revived and re-energized. They want everyone to know that they got their books. Being a part of this study has enriched me personally and added vitality to the work I do as a chaplain.

The process creates an increased sensitivity and attentiveness to the needs of those faced with chronic or life-limiting illness. It generates a wealth of resources that could be explored and offered not only to cancer patients but also to other patients. Giving voice to people helps them remember what their faith, beliefs and values can do to enhance their coping with illness.

_Beba Tata, BCC, is a staff chaplain Mayo Clinic Rochester, MN and Transforming chaplaincy Research Fellow_
Money, money, money: Serving God, not mammon, at the end of life

By Anne Millington

“No one can serve two masters, for either he will hate the one and love the other; or else he will be devoted to one and despise the other. You cannot serve both God and mammon.” (Matthew 6:24)

Kathy¹ sat in the ICU, tears filling her eyes. Her father, John, was dying, and the time had come for comfort measures only. Kathy knew it, her siblings knew it, her father’s girlfriend, Donna, knew it. As her father’s healthcare proxy, Kathy had expected to sign the paperwork. But to her shock, the nurse announced, “Donna’s the healthcare proxy. We’ll need Donna’s signature.” The story rapidly emerged. Donna and John had secretly married the prior week, and Donna had been quickly named not only his healthcare proxy but also the sole beneficiary of his entire estate. Apparently, John had been very hurt by Kathy and her siblings’ lack of attention to him in his declining years, and in vengeance chose to “surprise them” by leaving everything to Donna.

Death is a major event, physically, emotionally and, yes, financially. Whether the person dying has vast assets or vast debts, in death that person permanently leaves everything to heirs. While pretty much everyone knows in their bones that “you can’t take it with you,” Jesus’ words in Matthew’s Gospel nevertheless acknowledge the power of mammon to be a master that we serve. In a perfect world, assets transition peacefully and fairly, honoring loving relationships, honoring a life well lived. The world is not perfect, though, and Kathy and her siblings had just found this out, experiencing hurt and betrayal that has scarred them to this day. When wealth masters us, we give in to our baser instincts of greed or miserliness. When wealth masters us, we give up on human relationships, on our efforts to foster, deepen and heal our loving connection to others. When wealth masters us, we wield it as a weapon to punish, to avenge, to wound.

As chaplains in end-of-life situations, we are naturally called to support people in choosing God as their master, prioritizing loving God and loving each other. Our spiritual health, after all, depends on the love in our lives, on the quality of our relationships. Ideally, wealth should reflect and testify to that person’s loving relationships. Wealth bequeathed should honor those relationships fully and fairly, filling all its recipients with feelings of being cared for and loved. But … is wealth instead the mouthpiece for unresolved conflict? Are hard feelings about money the elephant in the room? Is there any evidence of sibling rivalry? Once we have a sense of wealth’s current role in a particular situation, we can try to nurse it into a healthier role, where it supports rather than devastates the spiritual health of all involved.

¹ Names and circumstances altered to maintain confidentiality.
Helen was an ICU patient whose oxygen needs had reached such a high level that she would require ICU care for the rest of her life. She was tired and ready to let go, and the medical team believed continued life support was only forestalling the inevitable. It was time to reconsider Helen’s “full code” status, to consider making her CMO. Nevertheless, Suzanna, Helen’s daughter and healthcare proxy, would not sign the paperwork. “She’s scared,” Suzanna claimed. “She is not ready to give up, not just yet. She could improve. I’m praying for a miracle.” But as the days dragged on, we learned that Suzanna lived in Helen’s house largely because she had no income and nowhere else to go, and there were such large liens on the house that once Helen died it would be lost to creditors. Was Suzanna prolonging Helen’s dying in order to have a place to live? We cannot have known without asking — and even asking might not have resulted in a clear or honest response. Nevertheless, a question like “How will you cope financially after Mom dies?” might have at least given space to the voices of any unspoken motives and particularly to any shame Suzanna’s self-serving behavior might be causing. Although spiritual distress was thick in the air, the situation resolved when Helen suddenly passed away, while still on oxygen, and the immediate need to probe Suzanna’s motives disappeared.

While shame may have a stake in end-of-life money matters, guilt may abound as well. Julia appeared very sad now that her great-aunt Vivian had been placed in hospice care. She opened a photo album to show me Vivian’s pictures from her years as a professional dancer and actress. Tears streaming down her face, Julia proudly recounted how Vivian had been famous in her day and had accumulated significant accolades and wealth. “I know she can hear me,” Julia whispered tearfully, gesturing towards Vivian, who was lying sedated in bed, “I keep telling her it’s OK to die now, but I know she’ll just keep living as long as she can to spite me.”

Her words struck me as odd. But she explained that Vivian had been a difficult and demanding personality, quite a diva even. She had never married or had children, and she had been estranged for years from most of her blood relatives. And yet Julia was her next of kin, Julia was her sole heir. Julia, who had been poor all her life, would now be wealthy. Julia felt guilty for being in line for this windfall, and Vivian had deepened that sense of guilt, claiming that all Julia cared about was money, and that she did not deserve to inherit it at all.

“How do you feel about becoming wealthy?” I asked Julia. Her face instantly exploded in glee, despite her intention to hold everything in with her tears, “I am so excited!” she responded. And then her face quickly turned crestfallen. “But I promise to put it all to good use, to spend the rest of my life giving back, doing for others.” Well aware now of Julia’s guilt, I looked at her and said, “Julia, it is not your fault that you are Vivian’s heir.” Relief swept over her face. She had done nothing wrong, and I only wish Vivian had been able to join in Julia’s joy over her upcoming wealth, honoring their connection as blood relatives, maybe even making up for lost time together, maybe even learning to love and be loved by one another. I was glad at least that I had given her at least a moment to express her joy, a brief pause from the guilt she carried.
Fortunately, there are times where hurt, shame and guilt can be nipped completely in the bud. I recall a visit I had with Dottie and her husband Richard. Richard was in the hospital yet again. He had dementia, along with a number of cardiac issues, and the daily stress of caring for Richard was truly taking its toll on Dottie. Although she had two daughters who lived nearby, neither of them had been very involved in Richard’s care. “I have written both girls out of our wills, even though they don’t know it,” Dottie declared to me bitterly, “because they have not offered enough help. And I have written a letter to the girls expressing this, and I have told my lawyer to read it to them once Richard and I have both died.” Jolting straight up in my chair, I blurted, “Don’t do it! Talk to your daughters now!”

Later that day, I apologized for trying to tell her what to do, and yet I could see that my words had resonated. Soon after, Dottie sat down with her daughters and expressed all of her disappointment in them, all of her anger, all of her sadness. And her daughters not only heard her, they also responded. They apologized for their unintentional negligence, and from that day forward played a much more active role in Dottie and Richard’s lives. While caring for Richard is still draining, these days Dottie looks more peaceful, more content. Her daughters are now there for her, she has reinstated them into her will, and the bitter deathbed letter has been torn up.

As patients and their families approach death, we chaplains encourage the dying to place God’s love on its proper and fitting throne, relegating their wealth directly into love’s service. This is not always easy, especially because shame, guilt and other strong emotions often shush talk of wealth. And yet love, truly, is stronger than death. Love lives on, long after our bodies have crumbled and our assets have dispersed. By encouraging people to serve God’s love rather than mammon’s tug, we lead others to see God in all things, to see Christ in all things, even and perhaps especially in the sorrow that still comes with dying and death.

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Ethics and end-of-life care: Embracing the mystery

By Fr. Patrick Norris, O.P.

In my ministry as a hospital chaplain/ethicist, one of the most difficult ethical decisions people encounter is end-of-life care. “Should I try one more chemotherapy treatment that has a small chance to cure but also might shorten my life?” “Am I killing my loved one if I choose not to put in a feeding tube?” Or sometimes it’s the clinicians who are frustrated with families and their requests for seemingly “futile care” for their loved ones.

Today, these end-of-life decisions are made more difficult by the realities of our death-denying culture, the proliferation of medical treatments and their costs, legal concerns that sometimes inhibit sound ethical care, and the breakdown of family structures that might result in heightened emotions and less certainty about patient preference. The following are 10 ethical considerations that I regularly keep in mind to help clinicians, patients, and loved ones.

1) Ethical Norms for End-of-Life Care: They are actually relatively straightforward. Generally, we have a duty to try to preserve life as stewards of that gift from God. However, if a life-sustaining treatment (e.g., antibiotics, ventilator, blood transfusion) is ineffective, or disproportionately burdensome compared to its benefits, individuals are not morally obliged to take it. When a patient subsequently dies, the moral cause of death is the underlying condition or illness, which a patient no longer had a duty to circumvent. This approach allows us to find a middle ground between euthanasia and preserving life at all costs (vitalism). Chaplains can help people consider not just the physical impact of the treatment, but the psychological, emotional, social, intellectual, financial, spiritual, and religious effects. I often encounter patients who simply have lived a good life and are ready “to go home to God.” Chaplains can affirm people in the decision to admit our mortality, recognizing that sometimes further treatment is prolonging death rather than preserving life. Helping patients or loved ones see this ethical framework can alleviate the false sense of guilt about violating the will of God in allowing natural death.

2) Withdrawing vs. Withholding: In particular, I have found loved ones struggle more with withdrawing life-sustaining care than withholding it. Chaplains can explain how there is no ethical distinction between the two — the same aforementioned norms apply in either case. Sometimes people might feel in removing treatment that they are somehow causing the death of the loved one: “If I didn’t remove the ventilator, my loved one would continue to live.” However, in accord with the ethical principle of double effect, we always must distinguish between physical causality and moral culpability, which has more to do with intentionality or motive.

3) Applying Norms in the Concrete: This is the challenging part. It is a well-known ethical maxim that as we move from principles to norms to concrete decisions, our ethical certitude decreases. Everyone can agree to do good and to avoid evil. However, what decision should be made in the ICU with this patient and in this set of circumstances is often less clear. Decisions are made even murkier when the medical data is insufficient. In the midst of uncertainty,
decision-makers can become paralyzed, concerned about going against God’s will. I remind people that God can only expect us to make the best decision possible with the data we have (what ethicists call moral certitude). If God wants something more (metaphysical certitude), then I tell people God must send us a text or email. God cannot demand the impossible. We cannot demand the impossible of ourselves or others.

4) Clinician Disagreement: This can be a particular problem if there is significant turnover in specialists during the course of a patient’s stay. Primary care providers who often know the patient well are rarely involved in hospital care. In addition, clinicians and patients process information differently. Patients or loved ones often assume they will be in the 10 percent who do well, while clinicians might assume the patient will be in the 90 percent who do not. Patients/loved ones might be reluctant to confront the clinician. But they might confide their frustration and confusion to the chaplain. Chaplains sometimes can empower them to raise this issue with the clinicians or suggest a family conference to help get everyone on the same page.

5) Patient Wishes: Loved ones ideally are supposed to make decisions based on the desires and values of the patient (substituted judgment standard). Unfortunately, at times, loved ones do not know what the patient would have wanted because they never talked about it (“Who wants to discuss end-of-life care at Christmas dinner?”) or the situation is unanticipated (“We never talked about being paralyzed from Guillain-Barre syndrome!”). And even when there have been discussions, many studies show that loved ones and clinicians are still inadequate at anticipating what patients would want. We try to combine a sense of a patient’s expressed wishes and values and a more objective best-interests approach, taking counsel from as many people as possible to rule out any biases.

6) Advance Directives: One way chaplains can reduce this ethical uncertainty is to promote the use of advance directives,* not just as a legal document (appointing an agent right before a surgery), but an ethical document by encouraging discussion with loved ones and their clinicians. As a person’s illness advances, they can go through a series of first steps, then next steps, and then final steps conversations.

7) Patience in the Real World: As chaplains, we can remind clinicians, patients, and loved ones how difficult these decisions are. Sometimes clinicians who deal with death and dying every day forget that this is the first time this wife has faced the potential death of her husband. Consequently, with all parties involved, encouraging patience is important. Sometimes in the midst of an ethical impasse with a family, when clinicians and the ethics committee feel that life-sustaining treatment is futile, the solution might lie in not stopping all treatment, but at least not escalating it while loved ones come to grips with reality. We all strive for perfect solutions, but as theologians have reminded us, sometimes the perfect can be the enemy of the good. In getting from point A to point D, some people need to move through the more imperfect points of B and C until they have the courage to make the optimal decision.

8) Dysfunctionality: That being said, chaplains can play an important role in facilitating sound end-of-life decisions in the midst of dysfunction. Be aware of guilt (“I’ve not been around
enough and so I show my love by asking that everything be done for Mom”) or a poor understanding of an individual’s statement such as “I want everything done to save my life.” Often people don’t realize what “everything” means these days, given high-tech medicine. Also, be aware of bad reasons for forgoing treatment, such as untreated depression, a mistaken interpretation of medical information, or a vague directive (e.g., a patient who didn’t ever want to be on a ventilator but in fact would have accepted a short-term trial).

9) **Addressing Fears:** Often, this is where the spiritual and the ethical intersect. For instance, a request for inappropriate treatment could be rooted in a particular fear of dying that has never been addressed. Chaplains can enter into that emotional/spiritual world of patients to address those fears and concerns. Chaplains can also enter this space when patients seem to be refusing treatment prematurely or (in some states) might be requesting aid in dying. In the context of finding hope in the midst of suffering, chaplains have a duty to try to explore the patient’s concerns about losing control, feeling abandoned, being a burden to loved ones, losing function, and experiencing unrelieved pain. Collaboration with the palliative care team (including a designated palliative care chaplain) is crucial when multiple areas of suffering are present to make a sound ethical decision.

10) **Exploring Miracles and Hope:** I could devote an entire article to the hope of a miracle, but chaplains can be invaluable in exploring loved ones’ or a patient’s understanding of miracles, their theological perspective of the intersection of the natural and supernatural, their previous experience with the seemingly miraculous, etc. Through their listening presence, chaplains can discern the belief that is driving the behavior that might be impeding sound ethical care. A priest friend always tells people: “Keep hope alive.” As chaplains, we can do that by helping loved ones and patients discover where hope can be found beyond the miraculous in their worldview. That is, as what we hope for changes from cure to life-extension to comfort, can we help people discover whom or what they can put their hope in?

Human beings long to have control and certainty, but healthcare contains great ambiguity—not only medical but ethical. For chaplains, being aware of those ethical ambiguities and how to mitigate them can help us to work with clinicians, patients, and loved ones—not only to embrace mystery at the end of life but find good (not always perfect) solutions to the ethical questions of modern healthcare.

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* See “Education about advance directives can pay dividends later” by Diane McCarthy, also in this issue.
Naming our beloved: A day of honoring loved ones’ grief

By Anne M. Windholz

He was a man of sorrows, acquainted with grief, and we hid our faces from him as from one despised, and we esteemed him not. — Isaiah 53: 3

Saturday morning, I had just arrived in NICU to meet a baby whose mother had died the day before — a tiny boy named Oliver Gabriel — and my pager went off. That pager was a manic thing on Saturday, always crying out just when I felt in the midst of some truly important ministry. Nothing mattered to me more than that baby boy, loving him, and supporting the NICU staff who was loving him as well.

But the pager let out its manic “Crisis—now!” howl, and I hurried to the emergency room, where I found two grown children waiting word on their elderly father. One of the ED surgeons was coming to the consulting room just as I arrived. He was dark and thin and tall, and his face was somber. Their 82-year-old father had a huge blood clot on the brain, he told the siblings. They could do surgery, but his chances were minimal. If he did survive those bleak odds, then likely the best the family could hope for was that he might afterward be able to recognize his children. If that. He would almost certainly be disabled.

This was an unexpected blow to both son and daughter, particularly the latter, who insisted passionately that they must try the surgery, that they couldn’t let him die as long as there was any chance. The son seemed to concur. The surgeon looked troubled. They asked more questions. The surgeon gave his opinion based on 30 years’ experience — once in all that time he had had a patient in a similar condition have surgery and come out almost as good as new. He put his hand on the son’s shoulder, his eyes full of concern. Once.

The children called their mother, who was in Ireland. She was adamant — we all heard her on speaker phone. “He wouldn’t want this. He wouldn’t want less than full life. Don’t let him suffer.” The children called other siblings. Most of those far away, only present on the telephone, were clear: Dad wouldn’t want to suffer. Those present with him found things less obvious. The doctor and I walked the siblings from the muted light of the waiting room to the unyielding brightness of the ED theater. Their father, intubated, was breathing with that mechanical regularity, which comes with a ventilator. He was a distinguished-looking man, with handsome white hair and beard. His eyes, partially open, were fixed, undilating. Two more sons arrived. The anguished debating continued.

Another surgeon came in. He was short and eager and seemed to consider surgery possibly worth it. I had been mostly quiet throughout, but given what I’d learned from the children about their father — an Ivy League PhD who had worked for decades at the Argonne Laboratory — I was feeling uneasy. I felt I had to ask a question that I knew was important in situations like this.
“What is most important to your father in his life? What does he most value? That might give us a clue as to what he would want.”

All the children answered without hesitation. “His work. He always wants to be behind his messy desk. He loves his work. His mind has always been good, even as he’s gotten old. He loves thinking more than anything else.” They looked at each other, and the sister burst into tears. There was no longer, really, any question about how to proceed.

Awhile later, we stood around the patient’s bed in CCU. He was on the ventilator still because the family was waiting for an aunt to arrive. When she came, they would extubate. I was pulled aside by another brother; his dad was an atheist, but he was Christian. This brother was struggling, not with the decision, but with the loss. He was struggling against his own grief. I tried to normalize it for him. Outside, rain was falling in torrents. I felt intensely present in that room. I didn’t want to be anywhere else.

And the pager let out its manic howl. “We’ve had a cardiac death,” said ED. “We need you now.”

I explained the situation to the CCU nurse and the family, promising to return when I could. And then I was walking furiously fast down the corridor. Beyond the windows, the rain poured with a push of the wind in almost horizontal sheets. At some points in the hallway, water leaked across the floor. I stepped gingerly through a small lake and thought, “This is a lawsuit just waiting to happen.” I stopped to catch my breath at the main desk. “You’d better call someone — a visitor might slip,” I told the girl there and raced on.

The clerk in the ED was direct with me. “It’s a Jane Doe, but the family is in the consulting room. You might want to check before going in — the husband doesn’t know she is dead, and he is angry.”

Outside the consulting room, which had seemed so peaceful a few hours before, I found three security guards. I could hear the doctor talking inside the room — it sounded like the tall, thin doctor I’d encountered earlier. Another man’s voice rose, angry, and insistent against the doctor’s quiet calm. The security guys told me not to go in, though the door was open. “He’s in there with his son. The son’s a big guy. Stay here.”

It was easy to tell when the doctor at last told the husband that his wife had died. We heard violent movement, a thunderous cry and moan, and then many voices raised in horror and protest. Two of the guards entered the room. The sounds of grief were intense. I spend my days with death, but I had never heard such loud outcry before.

Perhaps five minutes passed. Or maybe it was only two. It seemed long. The doctor came out with the nurse. The grief continued. But there were no more sounds of loud movement. One of the guards ushered me in. The husband was crouched on the floor beside a chair, sobbing,
begging his wife’s forgiveness. His bear of a son had his arms around his father, crying as well. Another son, with black T-shirt and tattooed arms, stood nearby, face crumpled.

At some point, a guard closed the door and I realized I was alone in the room with just the family. The sole hospital representative. It took me aback, and I prayed, “Well, Lord, hold us all up.” Then I just let go of everything but the people with me — there was nothing else to do. I had to let go and join them at the foot of their cross.

Remembering brings tears to me now. I feel deeply that we were unfair to that husband and his family. His rage was only right. His wife was 47, they were getting ready to leave on a vacation, and she collapsed just as the airport taxi arrived. In the hubbub that followed, the husband misunderstood which hospital she was being taken to. He ended up at one in another suburb, while she was delivered as “Jane Doe” to our facility. He was right to be angry. While I was with the family, the burly son at one point warned me, “Move back a little — when he gets up he might swing.” I did so, but was not afraid. The husband wasn’t drunk. He’d simply had his heart shattered.

It took two hours — at least — to calm him as the rest of the family gathered, all unabashed in their grief. The husband found it wrenching to face going to the room where she lay, knowing that once he saw her, “there will be no going back. She’ll be gone.” I knelt next to him and talked very low.

“She needs you,” I said. “They’ve called her Jane Doe. You love her. You have to love her now in a way harder than you have ever loved her. You have to go to her and give her her name. You have to own her, so she’s not alone.” He groaned, struggling to control himself. Then he put on his glasses and looked to his children.

I led all of them to her. And as the husband walked behind me, his daughter holding his hand, I kept thinking of his wedding day, when he probably walked down some flower-strewn aisle to his wife as she stood waiting for the life they would share together. And now he was walking to her again. To something very different.

That was a rough and tough family, all black T-shirts and tattoos. But they loved each other beautifully, and I will never forget how when the husband’s father arrived, he was so thoughtful and strong and kind. He actually gave me strength, though he couldn’t know it. I found it hard to explain to that husband, who had hoped to be with his wife on an airplane to somewhere lovely, about the release of body form, about the coroner, about the autopsy. But I was glad to be doing that job, glad to honor that family’s love by making this day as gentle as I possibly could for all of them. And I couldn’t do it alone.

The last thing I did was witness the charge nurse when she removed the woman’s wedding rings. As she worked the silver bands over somewhat swollen fingers, I noticed the dead woman’s nails — so lovely, painted a pretty pink with pale swirls of white and sparkles on them.
Romantic. For the trip she had meant to take that day. I hope the destination she arrived at instead was, for her at least, graced with peace.

Hers was not a praying family. But they gave witness to great love.

We, as a culture, too often reject and despise grief. We lock it up behind funeral parlor doors, tuck it into a brief memorial ceremony, give it the attention of a few sympathy cards and a postage-size obituary — and then expect it to be gone. Because we still value stoicism, say what you will about how we’ve learned to accept sorrow better since 9-11. And we are a people dreadfully afraid of pain and loss. So when a man expresses his anger and grief — whether he is tossing money-changers’ tables at the Temple or collapsing violently to the floor upon learning that his wife is dead — we label him a danger. A threat.

A man of sorrows, acquainted with grief. And we esteem him not.

Peace be to him. Peace be to them all.

The wife, by the way, had a name: Diana Selene. Like the orphan baby up in NICU, her name was beautiful.

When I left the hospital Saturday night, well after the end of my shift, the nuclear physicist in CCU was still breathing — on his own. He had survived the extubation. I saw him. His face was full of peace, the room full of his children. They were quiet and calm, supporting each other in their sorrow and loving their dad all the way to his destination. The storm was over. I got in my car and drove over still-wet highways to home.

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Anointing of the sick gains meaning with others present

By Fr. Justin A. Freeman

Sickness and serious injury are among the most isolating events that a person experiences in his life. The sick person is physically, and often, socially isolated. He or she is confined to an institution or home, prevented from participating in social and cultural avocations. The social isolation and loneliness can be more psychologically painful than the underlying disease.

Sickness also brings spiritual distress and a sense of abandonment by God and the community. Chaplains are often asked by patients why God is punishing them and whether they have been abandoned by God. The Scriptures are filled with examples of how illness brings about a crisis in faith to even the most devout believers. In Psalm 88, the psalmist laments that he is “shunned by his acquaintances” and “made loathsome” to them. Even more, the psalmist asks, “Why do you reject my soul, LORD, and hide your face from me?” (v. 15).

The sacrament of the anointing of the sick counters these isolating tendencies and sense of abandonment. It continues the healing work of Jesus, who not only brought about physical healings, but removed the barriers that kept the sick from encountering God and participating fully in the community.

The sacrament brings about communion with God and spiritual re-integration with the community of believers. For this reason, it is important that chaplains emphasize the communal nature of the sacrament by encouraging the presence of family, friends, and even medical staff whenever the sacrament is administered by a priest. In this way, the patient will know that the entire Church is praying for him or her in a particular way.

The rite of the sacrament is inherently communal. The oil is normally blessed by the diocesan bishop in the presence of his presbyterate at the Chrism Mass celebrated during Holy Week, so the Church reminds the sick that the entire community is praying for them. One of the closing prayers of the ritual asks that the person be comforted by the prayers of God’s “holy people.” Communal anointing services, which have been celebrated at the parish level since the Second Vatican Council, serve to remind the sick that the entire Church is praying for them.

Chaplains play an invaluable role in catechizing patients, family members, and staff about the communal nature of the sacrament. Chaplains can help foster a communal understanding of the sacrament in a variety of ways.

First, attempt to involve as many loved ones as possible in the celebration of the sacrament. If the patient is not imminently dying, then the family and priest can coordinate a mutually convenient time for loved ones to gather at the bedside to pray. Praying together as a family with the sick present helps to foster solidarity.
Second, invite willing medical and support staff to pray with the priest, family members, and sick person. Hospital staff have told me how powerful and meaningful it was to be included in the rites for the anointing of the sick. Once I anointed a severely ill young woman in the intensive care unit who was intubated and sedated. No family or loved ones were present. The only person in the room was the custodian, but together, she and I prayed as I anointed the patient.

Thirdly, hospital chaplains can invite patients and families to request the sacrament as soon as possible. Few things are done well in haste, and inevitably, complications might arise. As the former priest chaplain of a level one trauma center, I have anointed people in the trauma bay, while they were coding, and in the operating room. While God’s grace is still present, the inherently communal structure of the sacrament does not come through in such moments.

Chaplains have a valuable role in educating people about the communal nature of the sacrament of the anointing of the sick. We can teach the sick and family members that the entire Church suffers with them and is praying for them by thoughtfully and pastorally inviting other people to participate.

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Mementoes of children’s lives help parents through grief

By Jim Manzardo

“Could I take his feet home with me?”

In most any other context, this comment would seem jarring, but sitting next to her son, Patrick, who a short while earlier had died, this mother’s words made all the sense in the world. She was experiencing the beginning of the most intense grieving one can ever know and anticipating the next most painful part of her grieving — leaving her son’s body.

As she held and caressed Patrick’s pale, cold, stiff hand, this mom was lamenting that these moments would be her last to touch her son. Like other grieving mothers before her, she asked how she would go on living without him. She had known the greatest of all loves, for which she had given her whole self. Now she was suffering the harshest and most terrifying of all griefs. If we encounter the divine in relationship and in children, then indeed the love of parents for their children ought to be the most intense, most divine, and the most heart-wrenching when a child dies.

The mother’s caring boyfriend tried to console her, assuring her that his spirit would always be with her. She nodded and agreed that Patrick’s body was just a shell of him. Yet I knew from experience that though I referred to him as a body, he was still Patrick to this mom. Her boyfriend also reminded her that she had her son’s foot mold to take home with her. At our hospital, when it is clear that a child is dying, we offer to families some specific memory-making options, including bereavement photography, hand and foot prints, locks of hair, a pre-death recording of their child’s heartbeat usually put to music, and a hand or foot mold. It is very much a team effort.

We are fortunate to offer the service (or really the ministry) of a sensitive, empathic, and compassionate photographer who spends time at the bedside with the family, capturing in black and white the most tender moments of families touching, kissing, cuddling, lying with their dying or just deceased child. He later develops the best photos and presents them to the family in an album. My music therapy colleague has a special stethoscope with which she records the heartbeat of a dying patient and then, if families wish, overlays it with music significant to their child. Also, as my art therapy colleagues work with patients who have life-threatening illnesses, they are keenly aware that each project a child creates may be a legacy piece for that child’s family.

Having worked for more than 23 years at this same pediatric hospital, I have become known as an expert in making hand and foot molds. This delicate, creative task is not something my chaplain colleagues, nurses, or I went to school for, nor is it found on our job descriptions. But we each have felt a certain privilege in being able to contribute to something so valued by grieving families. Some families frame them and display them somewhere in their home. Others keep them on a shelf in the box we provide, inconspicuous on the outside, but very much known to the family. One mom said that almost every day as she walks by the mold, she gently touches the hand of her daughter.
These photos, recordings, artwork, locks of hair, prints, and molds are really not objects to help parents remember their deceased children. Though fearing it, no parent ever forgets a child who has died. Rather these objects can serve as lifelines after parents must tear themselves away from their child’s body, a life preserver that keeps them from drowning in the initial tsunami of grief, and relics that give parents a physical connection to what is essentially their own and their child’s passion.

Absolutely nothing and no one, not even another son or daughter, can ever take the place of a deceased child, but for many parents whose child has just died, having something they can see, feel, touch, smell, hear of their child, can in a small way be a comfort during parents’ agonizingly long period of separation, until they encounter their children again in the next life.

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Christmas lights help wife face new reality

By Fr. Larry W. Weidner

John, in his late 60s, having been diagnosed with Stage 4 cancer with only weeks to live, decided to forgo any treatment and live his final days with whatever time God was going to give him. His oncologist asked for a spiritual care visit.

Walking down the hall, I observed the maintenance staff putting up the artificial Christmas tree in a waiting area. As I walked into the room, John and his wife were having a lively conversation that ended abruptly.

The patient did not look as if he was in the final stage of his life. His wife appeared more upset than he did. Mary told me that she simply did not know what she would do without him. “He does everything. He pays all the bills, takes care of the house, the yard, the car. I can’t imagine what I’m going to do without him,” she bemoaned. John tried to comfort her by telling her that she was stronger than she thought.

After the two of us quietly listened to her concerns, I asked whether I could offer a prayer. They agreed. But as I was about to leave, I stopped. “By the way,” I said, “may I ask what you two were discussing when I walked into the room?”

“Oh, he wants me to put the damn Christmas lights up on the outside of the house,” the wife said. “With everything going on, he’s dying and he wants me to put the Christmas lights up! The last thing on my mind is Christmas. Can you believe him?”

Looking at him and then her, I said, “Do John and me a favor. Put up the damn Christmas lights!” She looked shocked, but I said, “I’ll stop by tomorrow,” and I turned and left.

The next day when I entered the room, the two of them were talking. There was even some laughter. It was apparent that they had moved beyond the doctor’s news of John’s diagnosis and her initial shock and panic. I also noticed a nighttime picture of a house with outside Christmas lights shining brightly. After a few minutes of conversation, I pointed to the picture and asked, “What’s that?”

“It’s a picture of our house,” said John, with a big grin on his face. “After Mary left here yesterday, she went home and put the Christmas lights up. She took this picture for me. Don’t they look great? I’m so proud of her.”

Mary smiled at John, then looked straight at me and said, “So, tell me, Father, why did you want me to put up those damn Christmas lights?”

I said, “Mary, it wasn’t what I wanted, but what John wanted. Yesterday you were fearful. You shared that John does everything for you. You questioned what you would do without him. John needs to know that you will be OK when he’s gone. I think that John felt that if you could put up those outside Christmas lights, you could do anything. You did it, and I believe you can do anything. You have given John the best Christmas present ever — to know that when he is gone, you will be OK.”

John held Mary’s hand in his one hand and in his other hand held the picture against his chest. With tears running down her face, Mary looked away from John at me. “Thank you. Father, you do understand.”

We said a prayer together, and I left. As I was walking down the hall, I thought to myself, “When am I going to put the Christmas lights up on my house?”

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